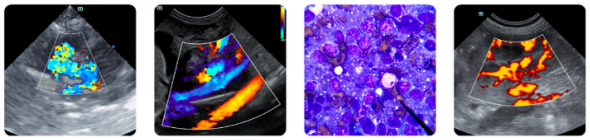

PATIENT

Abby Gindlesperger

SPECIES

Canine

BREED

Standard Poodle

SEX

SF

AGE

5 years

WEIGHT

52.1 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Mary Pearce

HOSPITAL NAME

Chambersburg Animal Hospital

REFERRING VET

Dr. Mary Pearce

INVOICE

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PRESENTING CLINICAL SIGNS

Presented for concerns of weight loss and vomiting episodes (last episode Sunday, none since). Decreased appetite, will not eat dog food but is trying to eat things outside, including mulch and wood pieces. Fresh bark mulch laid Monday, continued consumption 2-3 times that morning. Recently consumed rabbit fur-covered bone and another bone 2 days prior. Enlarged submandibular lymph nodes noted by client. Intermittent lameness of right hind leg, especially when rising from sleep or using steps. No diarrhea, coughing or sneezing. Weight loss: 54.9lb on 5/22/26, now 52.1lb.

Abnormal PE/Chem/CBC/UA Results: Mild to moderately enlarged, round submandibular LNs bilaterally. Popliteal LNs are mildly enlarged. No overt palpable lymphadenopathy elsewhere. Auscultation normal. Rectal exam found no masses, no palpable lymphadenopathy, formed fecal material with grass and bark-like material within. BW: 4Dx negative. CBC normal. ALT 50 (normal). ALP 224 (23-212) GGT 44 (0-11). tbili 0.3 (normal). Pancreatic lipase normal. Radiographs: post-prandial appearance to stomach with mineralized small pieces of foreign material throughout, no evidence of obstructive pattern. SI unremarkable. Colon full of formed fecal material with some mineralized material present. Mildly enlarged liver. Unremarkable thorax. FNAs performed of the peripheral LNs and submitted for cytology, pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (6.23 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

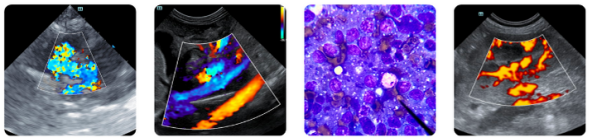
The right kidney has a normal shape and size (5.66 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.54 cm at the cranial pole and 0.6 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.78 cm at the cranial pole and 0.73 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen



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The spleen is subjectively normal in size (2.3 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. Some of the debris is characterized by sandy mineralized debris and small choleliths. Examples of small choleliths measure 0.42 cm and 0.48 cm. There is no evidence of bile duct dilation.

Gastrointestinal

The stomach is moderately dilated with large fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. Shadowing and ingesta interferes with full evaluation of some areas of the stomach.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate fluid and ingesta distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (0.46 cm in wall thickness) and the jejunum measured as normal (0.22 cm.) Visualized peristalsis appears appropriate. The small intestine appears gas and fluid distended, most consistent with a post-prandial patient.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are some clusters of prominent mesenteric lymph nodes. Examples measure 1.08 cm and 1.03 cm in diameter. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mineralized sandy gallbladder debris with some small choleliths. A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of lab work and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.
- Fluid/shadowing ingesta distended stomach and small intestines. Findings are most consistent

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with a post-prandial patient. If the patient was adequately fasted, then consider the possibility of delayed gastric emptying/ileus or small unseen focal lesions.

- Prominent mesenteric lymph nodes. Findings could be consistent with reactive lymph nodes or early neoplastic lymph nodes.

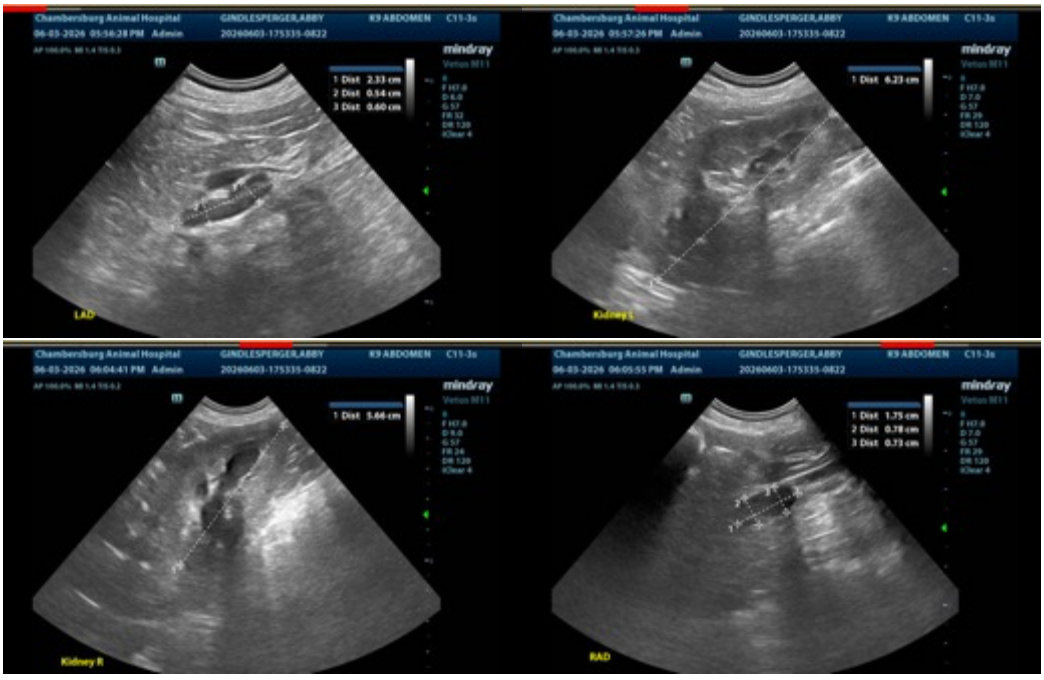
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach and small intestine appear fluid and ingesta distended. The gas and shadowing ingesta interfere with full evaluation. If the patient was adequately fasted, this could represent ileus. If symptoms are persistent then repeat evaluation with a more prolonged fast may be helpful to be able to more clearly visualize some areas of the GI tract.

There is a large amount of debris visualized within the gallbladder. Some of this is sandy mineralized debris and there are some larger areas most consistent with small choleliths. No definitive inflammation is noted. Recommend starting ursodiol and continued monitoring of the gallbladder.

There are some prominent mesenteric lymph nodes visualized. Your plan for aspirating a peripheral lymph node is a good one. Recommend continued monitoring. If cytology non-diagnostic and/or symptoms are persistent revaluation of the lymph nodes could be considered, and if a safe window for sampling is available, a fine needle aspirate could be performed for cytologic evaluation.

If underlying gastrointestinal disease is suspected you could consider a GI Panel to Texas A&M for a qualitative PLI/TLI, cobalamin, and folate to further evaluate. Additionally, a baseline cortisol could be considered.



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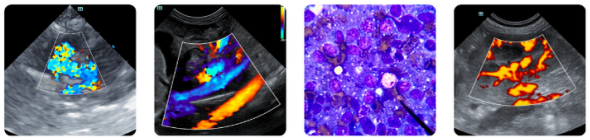

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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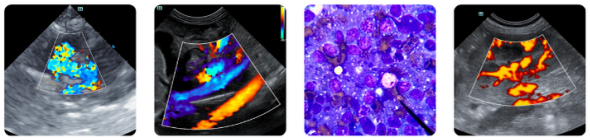

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